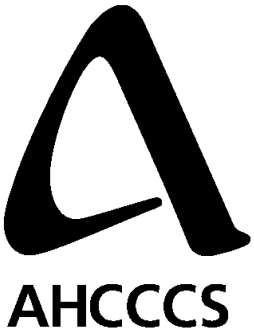
Chapter 7

Medicare/Other Insurance Liability



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GENERAL INFORMATION

You must determine the extent of a recipient's third party coverage and bill all private insurance carriers and Medicare, including HMOs, prior to billing AHCCCS. AHCCCS maintains a record of each recipient's coverage by Medicare and private carriers. If a recipient's record indicates third party coverage but no Medicare and/or insurance payment is indicated on the claim, your claim may be denied.

If you have attempted to collect payment but the third party payer, including Medicare, has denied payment, enter a "Ø" in the appropriate Medicare/third party payment fields of the claim. This certifies that Medicare and/or the third party payer was billed but that no payment can be received.

You may not "zero fill" the Medicare fields on hospital inpatient and outpatient claims, with the exception of outpatient claims for pharmacy and dental services. Outpatient claims for pharmacy and dental services billed on a UB-92 claim form (837I for electronic claims) may be zero filled. You do not need to submit an EOMB with these claims. Make sure that these claims have a pharmacy or dental diagnosis code.

If other inpatient or outpatient claims are denied by Medicare, you must submit documentation of the denials with the UB-92 claims to AHCCCS.

AHCCCS will not pay for more than the recipient's financial responsibility for the service. AHCCCS will reimburse up to the Medicare deductible, coinsurance, or co-pay for services rendered to recipients with Medicare coverage, including recipients enrolled with a Medicare HMO. Contact the HMO for information regarding covered services and prior authorization.

Services that are not Medicare-covered services but are AHCCCS-covered services (e.g., pharmacy services, dental services, homemaker services, attendant care services, non-emergency transportation) may be reimbursed by AHCCCS if they are medically necessary and meet AHCCCS reimbursement requirements. However, Medicare-covered services that are disallowed by Medicare because the services were not medically necessary or were not delivered in an appropriate setting or because the claims were not filed properly will not be reimbursed by AHCCCS.

MEDICARE CROSSOVER CLAIMS

AHCCCS has established an automated crossover process for fee-for-service claims from providers whose Medicare carrier or intermediary is BlueCross/BlueShield of Texas (TrailBlazer Health Enterprises), BlueCross/BlueShield of North Dakota (Noridian), or BlueCross/BlueShield of Arizona.

When you submit a claim to Medicare for an AHCCCS recipient who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment. You should not submit claims to AHCCCS for paid Medicare claims for dually eligible AHCCCS recipients or QMB recipients. All Medicare crossover claims are identified on your Medicare EOB and your AHCCCS Remittance Advice.

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS (see below) within six months from the date of Medicare EOMB. A copy of the EOMB must accompany the claim to AHCCCS. These claims must achieve clean claim status within 6 months of the date of the Medicare EOMB, 12 months from the date of service, or 60 days of the last adverse action by AHCCCS, which ever is later, as long as the initial submission to AHCCCS was within 6 months of the date of service.

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE

When you find it necessary to file a CMS 1500 claim with AHCCCS for a recipient who also is covered by Medicare or other insurance, you must report Medicare and other insurance information on the claim to AHCCCS.

For recipients and services covered by Medicare

You must bill Medicare first. When payment is received, you may bill AHCCCS for the services as shown on the Medicare EOB. The coinsurance and deductible information is entered in Field 24K.

24 A						B	C	D	E	F	G	H	I	J	K
DATES OF SERVICE From MM DD YY			To MM DD YY			Place of Service	Type Of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances CPT/HCPCS MODIFIER	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

☑ Divide Field 24K with a diagonal or vertical line and report *coinsurance* to the *left* of the vertical line or *above* the diagonal line.

☑ Report *deductible* to the *right* of the vertical line or *below* the diagonal line.

- ✓ If the deductible has been met, enter zero (Ø) for the deductible.
- ✓ If only the coinsurance amount is entered in Field 24K, the amount is treated as a third party liability (TPL) payment, resulting in incorrect reimbursement.

Example 1: Provider reports coinsurance of $145 and deductible of $100.

K
RESERVED FOR LOCAL USE
145.00 / 100.00

or

K	
RESERVED FOR LOCAL USE	
145.00	100.00

Example 2: Provider reports $145.00 coinsurance and no deductible.

K
RESERVED FOR LOCAL USE
145.00 / 0

or

K	
RESERVED FOR LOCAL USE	
145.00	0

☑ If you report two amounts without a line separating the amounts, the first amount will always be considered coinsurance and second amount will be treated as the deductible.

Example 3: Provider reports $145.00 coinsurance and no deductible.

K	
RESERVED FOR LOCAL USE	
145.00	0

☑ For recipients and services covered by other third party payers, enter only the amount *paid*.

Example 4: Provider reports payment of $105.00 from a third party payer.

K
RESERVED FOR LOCAL USE
105.00

☑ *Always* attach a copy of the Medicare or other insurer's EOB to the claim.

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

For recipients with Medicare coverage but the service is not covered by Medicare

☑ You should "zero fill" Field 24K and submit the claim within the appropriate time frame.

- ✓ Leaving the field blank will cause the claim to be denied.
- ✓ Zeros indicate that no payment was received.

Example 5: Provider reports no payment received from Medicare.

K
RESERVED FOR LOCAL USE
0 0

or

K
RESERVED FOR LOCAL USE
0 | 0

or

K
RESERVED FOR LOCAL USE
0 0

Example 6: Provider reports no payment received from third party payer.

K
RESERVED FOR LOCAL USE
0

UB-92 CLAIMS WITH MEDICARE/OTHER INSURANCE

When you find it necessary to file a UB-92 claim with AHCCCS for a recipient who also is covered by Medicare or other insurance, you must report Medicare and other insurance information on your claim to AHCCCS.

For recipients and services covered by Medicare

You must bill Medicare first. When payment is received, you may bill AHCCCS for the services as shown on the Medicare EOB. You must attach a copy of the Medicare EOB to the UB-92 claim.

UB-92 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

☑ Medicare Part A

✓ Report the Part A deductible and coinsurance (if applicable) amounts and appropriate value codes in Fields 39A and 40A.

✓ Use value code A1 to indicate Part A deductible and A2 for Part A coinsurance.

Example 7: Provider reports Medicare Part A deductible of $812 and no coinsurance.

	39 VALUE CODE			40 VALUE CODE			41 VALUE CODE		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a	A1	812	00						
b									
c									
d									

☑ Medicare Part B - Inpatient

✓ Report Medicare Part B as the payer and the Part B paid amount in Fields 50B and 54B.

Example 8: Provider reports Medicare Part B Inpatient payment of $312.

50 PAYER	51 PROVIDER NO.	52 REL 53 ASG INFO BEN	54 PRIOR PAYMENTS		55 EST AMOUNT DUE	
A						
B MEDICARE PART B			312	00		
C						

☑ Medicare Part B - Outpatient

✓ Report the Part B deductible (if applicable) and coinsurance amounts and appropriate value codes in Fields 39B and 40B.

✓ Use value code B1 to indicate Part B deductible and B2 for Part B coinsurance.

Example 9: Provider reports outpatient Part B coinsurance of $125.

	39 VALUE CODE			40 VALUE CODE			41 VALUE CODE		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a									
b	B2	125	00						
c									
d									

UB-92 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

☑ Other third party payers

- ✓ Report the third party payer's name and payment amount in Fields 50A and 54A or 50B and 54B.
- ✓ Attach a copy of the insurer's EOB to the UB-92 claim.

Example 10: Provider reports a third party payment of $1,225.00.

50 PAYER	51 PROVIDER NO.	52 REL 53 ASG INFO BEN	54 PRIOR PAYMENTS		55 EST AMOUNT DUE	
A XYZ Insurance			1,225	00		
B						
C						

NURSING FACILITY CLAIMS WITH MEDICARE/OTHER INSURANCE

AHCCCS is responsible for reimbursement of Medicare coinsurance minus any other insurance payment, minus the recipient's share of cost (SOC).

When a nursing facility submits a claim to Medicare Part A intermediaries BlueCross/Blue-Shield of Texas (TrailBlazer Health Enterprises) and BlueCross/BlueShield of Arizona for an AHCCCS recipient who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment.

You should not submit nursing facility claims to AHCCCS for paid Medicare claims for dually eligible AHCCCS recipients or QMB recipients. All Medicare crossover claims are identified on your Medicare EOB and your AHCCCS Remittance Advice.

When a recipient has exhausted the Medicare benefit for nursing facility coverage, you must submit a claim to AHCCCS. You should "zero fill" the Medicare fields and submit the claim within the appropriate time frame. Zeros indicate that no payment was received. Leaving the fields blank will cause the claim to be denied.

NURSING FACILITY CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

Example 11: Provider reports no payment received from Medicare.

Value Code A2 = Medicare Part A Coinsurance

	39 VALUE CODES			40 VALUE CODES			41 VALUE CODES		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a	A2	00	00						
b									
c									

If payment from Medicare or another third party payer is received later, the claim must be adjusted.

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. You must initially submit these claims to AHCCCS within six months of the date of service or within 6 months from the date of the Medicare EOB, whichever is later. A copy of the Medicare EOB must accompany the claim to AHCCCS. These claims must achieve clean claim status within 12 months of the date of the Medicare EOB or 60 days of the last adverse action by AHCCCS, whichever is later.

RETROACTIVE POSTING OF MEDICARE ELIGIBILITY

Occasionally, AHCCCS learns that a recipient is eligible for Medicare after payment has been made to the provider. When that happens, AHCCCS recoups the money overpaid from future payments to the provider and advises the provider to bill Medicare.

AHCCCS also has contracted with Public Consulting Group, Inc. to identify inpatient hospital claims that are overpaid due to the late posting of Medicare eligibility.

AHCCCS has begun to systematically identify all members with retroactive Medicare posting for whom the agency has paid claims from both hospitals and other providers, without consideration of the potential Medicare payment. A report is reviewed monthly and allows AHCCCS to recoup any overpayments from all provider types.

When AHCCCS recoups, providers should bill Medicare and follow the procedure outlined earlier in this chapter.

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